or failed to act as specified in paragraph (a) of this section and affirms this determination in accordance with paragraph (c) of this section, HCFA may—

(1) Require the HMO or CMP to suspend acceptance of applications for enrollment made by Medicare beneficiaries during the sanction period;

(2) Suspend payments to the HMO or CMP for Medicare beneficiaries enrolled during the sanction period; and

(3) Require the HMO or CMP to suspend all marketing activities to Medicare enrollees.

(e) *Effective date and duration of sanctions*—(1) *Effective date.* Except as provided in paragraph (e)(2) of this section, a sanction is effective 15 days after the date that the organization is notified of the decision to impose the sanction or, if the HMO or CMP timely seeks reconsideration under paragraph (c) of this section, on the date specified in the notice of HCFA's reconsidered determination.

(2) *Exception.* If HCFA determines that the HMO's or CMP's conduct poses a serious threat to an enrollee's health and safety, HCFA may make the sanction effective on a date before issuance of HCFA's reconsidered determination.

(3) *Duration of sanction.* The sanction remains in effect until HCFA notifies the HMO or CMP that HCFA is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

(f) *Termination by HCFA.* In addition to or as an alternative to the sanctions described in paragraph (d) of this section, HCFA may decline to renew a HMO's or CMP's contract in accordance with §417.492(b), or terminate the contract in accordance with §417.494(b).

(g) *Civil money penalties.* If HCFA determines that a HMO or CMP has committed an act or failed to comply with a requirement described in paragraph (a) of this section (with the exception of the requirement to limit the percentage of Medicare and Medicaid enrollees described in paragraph (a)(7) of this section), HCFA notifies the OIG of that determination. HCFA also conveys to the OIG information when it reverses or terminates a sanction imposed under this subpart. In accordance with the provisions of 42 CFR part 1003, the OIG may impose civil money penalties on the HMO or CMP in addition to or in place of the sanctions that HCFA may impose under paragraph (d) of this section.

[59 FR 36083, July 15, 1994, as amended at 60 FR 45681, Sept. 1, 1995; 61 FR 13448, Mar. 27, 1996]

Subpart M—Change of Ownership and Leasing of Facilities: Effect on Medicare Contract

§417.520 Effect on HMO and CMP contracts.

(a) The provisions set forth in subpart L of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(b) In applying these provisions, references to ''M+C organizations'' must be read as references to ''HMOs and CMPs''.

(c) In §422.550, reference to ''subpart K of this part'' must be read as reference to ''subpart L of part 417 of this chapter''.

(d) In §422.553, reference to ''subpart K of this part'' must be read as reference to ''subpart J of part 417 of this chapter''.

[63 FR 35067, June 26, 1998]

Subpart N—Medicare Payment to HMOs and CMPs: General Rules

§417.524 Payment to HMOs or CMPs: General.

(a) *Basic rule.* The payments that HCFA makes to an HMO or CMP under this subpart and subparts O and P of this part for furnishing covered Medicare services are in place of any payment that HCFA would otherwise make to a beneficiary or the HMO or CMP under sections 1814(b) and 1833(a) of the Act.

(b) *Basis of payment.* (1) HCFA pays the HMOs or CMPs on either a reasonable cost basis or a risk basis depending on the type of contract the HMO or CMP has with HCFA.

(2) In certain cases a risk HMO or CMP also receives payments on a reasonable cost basis for certain Medicare enrollees who retain nonrisk status, as

provided in § 417.444, after the HMO or CMP enters into a risk contract.

[60 FR 46229, Sept. 6, 1995]

§ 417.526 Payment for covered services.

Subpart O of this part set forth the principles that HCFA follows in determining Medicare payment to an HMO or CMP that has a reasonable cost contract. Subpart P of this part describes the per capita method of Medicare payment to HMOs or CMPs that contract on a risk basis.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985; as amended at 58 FR 38080, July 15, 1993; 60 FR 46229, Sept. 6, 1995]

§ 417.528 Payment when Medicare is not primary payer.

(a) *Limits on payments and charges.* (1) HCFA may not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(2) The circumstances under which an HMO or CMP may charge, or authorize a provider to charge, for covered Medicare services for which Medicare is not the primary payer are stated in paragraphs (b) and (c) of this section.

(b) *Charge to other insurers or the enrollee.* If a Medicare enrollee receives from an HMO or CMP covered services that are also covered under State or Federal worker's compensation, automobile medical, or any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the HMO or CMP may charge, or authorize a provider that furnished the service to charge—

(1) The insurance carrier, employer, or other entity that is liable to pay for these services; or

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or other entity.

(c) *Charge to group health plans (GHPs) or large group health plans (LGHPs).* An HMO or CMP may charge a GHP or LGHP for covered services it furnished to a Medicare enrollee and may charge the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP for these covered services if—

(1) The Medicare enrollee is covered under the plan; and

(2) Under section 1862(b) of the Act, HCFA is precluded from paying for the covered services .

(d) *Responsibilities of HMO or CMP.* An HMO or CMP must—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act;

(2) Determine the amounts payable by these payers; and

(3) Coordinate the benefits of its Medicare enrollees with these payers.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46229, Sept. 6, 1995]

Subpart O—Medicare Payment: Cost Basis

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

§ 417.530 Basis and scope.

This subpart sets forth the principles that HCFA follows to determine the amount it pays for services furnished by a cost HMO or CMP to its Medicare enrollees. These principles are based on sections 1861(v) and 1876 of the Act and are, for the most part, the same as those set forth—

(a) In part 412 of this chapter, for paying the costs of inpatient hospital services which, for cost HMOs and CMPs, are considered ''reasonable'' only if they do not exceed the amounts allowed under the prospective payment system; and

(b) In part 413 of this chapter, for the costs of all other covered services.

[60 FR 46230, Sept. 6, 1995]

§ 417.531 Hospice care services.

(a) If a Medicare enrollee of an HMO or CMP with a reasonable cost contract makes an election under § 418.24 of this chapter to receive hospice care services, payment for these services is made to the hospice that furnishes the services in accordance with part 418 of this chapter.

(b) While the enrollee's hospice election is in effect, HCFA pays the HMO or CMP on a reasonable cost basis for only the following covered Medicare services furnished to the Medicare enrollee: